Section 3.9 Intake, Assessment and Service Planning

3.9.1 Introduction

ADHS/DBHS supports a model for intake, assessment, service planning and service delivery that is strength-based, family friendly, culturally sensitive and clinically sound and supervised. The model is based on three (3) equally important components:

- Input from the person and family/significant others regarding their special needs, strengths and preferences;
- Input from other individuals who have integral relationships with the person; and
- Clinical expertise.

The model incorporates the concept of a "team", established for each person receiving behavioral health services. At a minimum, the team consists of the person, family members in the case of children, and a qualified behavioral health clinician. As applicable, the team would also include representatives from other state agencies, clergy, other relevant practitioners involved with the person and any other individuals requested by the person. In addition, the model is based on a set of clinical, operative and administrative functions, which can be performed by any member of the team, as appropriate. At a minimum, these include:

- Ongoing engagement of the person, family and others who are significant in meeting the behavioral health needs of the person, including active participation in the decision-making process;
- An initial assessment process performed to elicit strengths, needs and goals of the individual person and his/her family, identify the need for further or specialty evaluations that support development of a service plan which effectively meets the person's needs and results in improved health outcomes;
- Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the person and input from the person and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan that are clinically sound, including referral to community resources as appropriate and, for children, services which are provided consistent with the Arizona vision and principles;
- Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of covered services is

important to achieving positive outcomes, (e.g., primary care providers, school, child welfare, juvenile or adult probations, other involved service providers);
- A Clinical Liaison assigned to each enrolled person to provide clinical oversight and ensure clinical soundness of the assessment and service planning processes (see Section 3.7, Clinical Liaison);
- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist persons who are moving to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an ALTCS Contractor); and
- Development and implementation of transition plans prior to discontinuation of behavioral health services.

3.9.2 References

The following citations can serve as additional resources for this content area:
- AHCCCS/ADHS Contract
- ADHS/T/RBHA Contract
- 9 A.A.C. 20
- 9 A.A.C. 21
- ADHS/DBHS Behavioral Health Covered Services Guide
- Child and Family Team Practice Improvement Protocol
- Instruction Guide for the Assessment, Service Plan and Annual Update
- SMI Eligibility Determination Section
- Behavioral Health Medical Record Standards Section
- Coordination of Care with AHCCCS Health Plans and PCPs Section
- Clinical Liaison Section
- Credentialing and Privileging Section
- Enrollment, Disenrollment and Other Data Submission Section
- Disclosure of Behavioral Health Information Section
- Member Handbooks Section
- Accessing and Interpreting Eligibility and Enrollment Information and Screening and Applying for AHCCCS Health Insurance Section
- Third Party Liability and Coordination of Benefits Section
- General and Informed Consent to Treatment Section
- Special Populations Section

3.9.3 Scope

To whom does this apply?

This applies to all persons who are receiving services in the ADHS/DBHS behavioral health system.

3.9.4 Did you know…?

There are six basic principles on which this section is based. Behavioral health assessments and service plans:

- Are developed with an unconditional commitment to persons enrolled in the behavioral health system and their families;

- Begin with empathetic relationships that foster ongoing partnerships and expect equality and respect throughout the service delivery system;
- Are developed collaboratively with families to engage and empower their unique strengths and resources;
- Include other individuals important to the person;
- Are individualized, strength-based, culturally appropriate and clinically sound; and
- Are developed with the expectation that the person is capable of positive change, growth and leading a life of value.

ADHS/DBHS has published the *Instruction Guide for the Assessment, Service Plan and Annual Update* as a resource for T/RBHAs and behavioral health providers.

3.9.5 Definitions

Annual Update

Assessment

Intake

Service Plan

Team

3.9.6 Procedures

3.9.6-A: Intake

Behavioral health providers must conduct intakes in an efficient and effective manner that is both "person friendly" and ensures the accurate collection of all the required information necessary for enrollment into the system. The intake process must:

- Be flexible in terms of when and how the intake occurs. For example, in order to best meet the needs of the person seeking services, the intake might be conducted over the telephone prior to the visit, at the initial appointment prior to the assessment and/or as part of the assessment; and
- Make use of readily available information (e.g., referral form, AHCCCS eligibility screens) in order to minimize any duplication in the information solicited from the person and his/her family.

What happens during the intake?

During the intake, the behavioral health provider will collect, review and disseminate certain information to persons seeking behavioral health services. Examples can include:

- The completion of the behavioral health client cover sheet (see PM Form 3.9.1);
- The collection of required demographic information and completion of client demographic information sheet (see Section 7.5, Enrollment, Disenrollment and other Data Submission);
- The completion of any applicable authorizations for the release of information to other parties (see Section 4.1, Disclosure of Behavioral Health Information). This is especially

critical for persons referred under the Corrections Officer/Offender Liaison (COOL) Program, who may have substance abuse treatment needs. See Section 3.19, Special Populations for more information;
- The dissemination of a member handbook to the person (see Section 3.6, Member Handbooks);
- The review and completion of a general consent to treatment (see Section 3.11, General and Informed Consent to Treatment);
- The collection of financial information, including the identification of third party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary (see Section 3.1, Accessing and Interpreting Eligibility and Enrollment Information and Screening and Applying for AHCCCS Health Insurance and Section 3.5, Third Party Liability and Coordination of Benefits); and
- The review of the person's rights and responsibilities as a recipient of behavioral health services including an explanation of the appeal process.

The person and/or family members may complete some of the paperwork associated with the intake, if acceptable to the person and/or family members.

What staff are qualified to complete an intake?
Behavioral health providers conducting intakes shall be appropriately trained, approach the person and family in an engaging manner and possess a clear understanding of the information that needs to be collected. Staff completing intakes must be behavioral health paraprofessionals, behavioral health technicians or behavioral health professionals but are not required to complete a specified privileging process.

What service codes can be encountered for activities associated with the intake?
The following list of service codes could be used when delivering an intake service (see the ADHS/DBHS Behavioral Health Covered Services Guide for a detailed description of each service code, provider qualifications and other limitations):

- **H0002-**Behavioral health screening;
- **T1016-**Case management by a behavioral health professional;
- **T1016 with modifier "HN"-** Case management by a behavioral health technician or behavioral health paraprofessional

3.9.6-B: Assessments

Behavioral health providers must conduct assessments that address the general components described in the introduction subpart of this section. ADHS/DBHS has established a standardized assessment that includes a "core" assessment and several additional assessment documents, or "addenda" that must be completed as applicable for specific populations (see PM Form 3.9.1). The core assessment (at a minimum) must be completed at the initial appointment by a behavioral health professional or a behavioral health technician privileged and credentialed to do so.

There are possible exceptions to completing the core assessment at the initial appointment. In an emergency situation, the person's immediate clinical needs must be initially addressed. At other times, it may be necessary to provide needed behavioral health services before

completing the core assessment (e.g., appointments with a behavioral health medical practitioner to assess the need for and/or to provide psychotropic medications). In these cases, the core assessment can be completed at the next appointment.

Additionally, for urgent responses to children removed from their homes by the Department of Economic Security/Child Protective Services, the priority at the initial interview is to address the child's immediate needs. At a minimum, the assessor should try and complete the CPS addendum along with the following Core Assessment sections: Risk Assessment, Mental Status Exam, Clinical Formulation and Diagnosis, and Next Steps/Interim Service Plan.

What is included in the "core" assessment?
The Medical and Behavioral Questionnaire (see PM Form 3.9.1, Part A) and the core assessment (see PM Form 3.9.1, Part B) are reviewed and completed at the initial appointment.

The following is a list of sections contained within the core assessment:

- Presenting concerns (must be completed at initial appointment);
- Criminal Justice (must be reviewed at the initial appointment and if indicated as necessary, the criminal justice addendum can be completed at a follow-up appointment);
- Substance Related Disorders (Part A must be completed at initial appointment, and Part B and C if indicated as necessary);
- Abuse/Sexual Risk Behavior (must be completed at initial appointment with some questions only completed if appropriate);
- Risk Assessment (must be completed at initial appointment with some questions only completed if appropriate);
- Mental Status Exam (must be completed at initial appointment);
- Clinical Formulation and Diagnoses (must be completed at initial appointment); and
- Next Steps/Interim Service Plan (must be completed at initial appointment).

What is included in the additional assessment documents ("addenda")?
The following addenda (See PM Form 3.9.1, Part C) may or may not be completed at the initial appointment, but must eventually be completed for specific populations and/or if otherwise deemed appropriate by the assessor based on other information learned during the assessment:

- Living Environment (for all persons);
- Family/Community Involvement (for all persons);
- Educational/Vocational Training (for school age children and adults if appropriate);
- Employment (for persons 16 years and older or as pertinent);
- Developmental History (for all children and for adults who have developmental disabilities);
- Criminal Justice (for persons with legal system involvement);
- Problem Gambling Screening (for persons age 16 and older when applicable);
- SMI determination (for persons who request an SMI determination or who have a qualifying SMI diagnosis and a GAF score that is 50 or lower); and
- Child Protective Services (used for 24 hour urgent responses for children removed by CPS).

What else must the assessment process include?

- Behavioral health providers must use the ADHS/DBHS core assessment (See PM Form 3.9.1). Behavioral health providers may reformat the standardized assessment to place it on agency letterhead or to use it in an electronic format; however, the individual questions must be covered in their original order. Any changes or additions to the standardized assessment must be reported to the T/RBHA and ADHS/DBHS for approval. It is understood that questions may be adjusted during the actual interview to account for the level of understanding of the interviewee or the flow of the conversation, however the recorded answers must be placed in the standardized location.
- Assignment of a credentialed and privileged behavioral health technician or credentialed and privileged behavioral health professional qualified to conduct the initial assessment. This person must serve as the Clinical Liaison unless another credentialed and privileged behavioral health technician or behavioral health professional is more appropriately matched to serve permanently in this capacity.
- For persons referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges. If the assessor is unsure regarding a person's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with a licensed medical practitioner with prescribing privileges.
- Be in compliance with timelines for services and appointments as specified in Section 3.2, Appointment Standards and Timeliness of Service including:
  - Completion of the other required addenda either at the initial appointment or during subsequent meetings. The addenda/modules are completed depending on the individual needs of the person, but it is expected that a comprehensive assessment allowing for sound clinical formulation and diagnostic impression must be completed within 45 days of the initial appointment. For persons seeking a determination for serious mental illness, the assessor should attempt to complete the entire assessment packet (core and all relevant addenda) before making an SMI eligibility determination. If this is not possible, the assessor can either:
    - Ask if the person would agree to an extension on the SMI eligibility determination and if they would agree to reschedule the appointment; or
    - Complete as much of the assessment as possible and make the SMI eligibility determination based on the available information. In either case, the assessor should use the Interim Service Plan to identify the next appointment during which the assessment process will continue. As new information is obtained, the SMI eligibility determination may be revised (see Section 3.10, SMI Eligibility Determination);
  - Required data element submission within 45 days (see Section 7.5, Enrollment, Disenrollment and other Data Submission); and
  - Completion of a person's initial service plan no later than 90 days after the initial appointment.
- Documentation of the assessment information in the comprehensive clinical record (see Section 4.2, Behavioral Health Medical Record Standards);
- In the event that a behavioral health technician completes the assessment, the information must be reviewed by a credentialed and privileged behavioral health professional; and

- Coordination with the person's PCP regarding assessment recommendations (see requirements set forth in Section 4.3, Coordination of Care with AHCCCS Health Plans and PCPs).

3.9.6-C: Service planning

Behavioral health providers in conjunction with the person's team must develop and implement service plans based on a person's initial and ongoing assessments. The person, family members and other involved parties as applicable, must be invited to participate in the development of the service plan. The service plan must incorporate the general components described in subsection 3.9.1, Introduction. ADHS/DBHS has established a standardized service plan format (see PM Form 3.9.1, Part D).

What else must the service planning process include?

- Behavioral health providers must incorporate the elements identified within the ADHS/DBHS standardized service plan and review of progress format (PM Form 3.9.1, Part D),
- In the event that a behavioral health technician completes the service plan, a credentialed and privileged behavioral health professional must review the service plan,
- Initial service plans must be completed no later than 90 days after the initial appointment,
- Documentation of the service planning information in the comprehensive clinical record (see Section 4.2, Behavioral Health Medical Record Standards), and
- Coordination with the person's PCP regarding service planning recommendations (see requirements set forth in Section 4.3, Coordination of Care with AHCCCS Health Plans and Primary Care Providers).

What if the person and/or legal guardian disagree with the service plan?

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member and results in consensus regarding the type, mix and intensity of services to be offered. In the event that a person and/or legal or designated representative disagree with any aspect of the service plan, the team should take reasonable attempts to resolve the differences and actively address the person's and/or legal or designated representative's concerns.

Despite a behavioral health provider's best effort, it may not be possible to achieve consensus when developing the service plan. The ADHS/DBHS standardized service plan (PM Form 3.9.1, Part D) includes an option for the person and/or legal or designated representative to either agree or disagree with some or all of the services included in the service plan.

In cases that the person and/or legal representative disagree with some or all of the Title XIX/XXI covered services included in the service plan, the person and/or legal representative **must** be given:

- A Notice of Action (PM Form 5.1.1) by the behavioral health representative on the team.

In cases that a person determined to have a serious mental illness and/or legal representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the person and/or legal representative **must** be given:

- A Notice of SMI Grievance and Appeal Procedure (PM Attachment 5.5.1), by the behavioral health representative on the team.

In either case, the person and/or legal representative may file an appeal within 60 days of the action.

3.9.6-D: Annual update

Behavioral health providers must complete an annual update that records a historical description of the significant events in the person's life and how the person/family responded to the services/treatment provided during the past year. The update process includes the following requirements:

- Use of the ADHS/DBHS standardized annual behavioral health update and review summary (See PM Form 3.9.1, Part E) that is completed by the person's Clinical Liaison or designee with the person and other relevant participants present.
- Behavioral health providers may reformat the annual update and re-order the questions to adjust to individual situations; however, the basic topic areas of each question must be covered.
- Based on the annual update, modify the person's service plan, if appropriate.
- Share, as appropriate, this information with other key individuals or entities such as the person's primary care physician, or DES/DDD case manager.
- Documentation of the annual update in the comprehensive clinical record.

The assessment and service plan may be updated more frequently as needed.